RESERVED

SPECIAL PAYMENT PROVISIONS

Transfers

If a patient is transferred between two hospitals both of which are paid under the prospective payment system the Department pays the transferring hospital the lesser of:

(1) A per diem rate for each day of inpatient care determined by dividing the hospital's appropriate DRG payment for the case by the State-wide average length of stay for the DRG; or

(2) The hospital's appropriate DRG payment rate.

Budget Neutrality Calculation

When the group average cost per case is rebased, the Department applies a factor to each hospital's group average cost per case to achieve budget neutrality. The factor is determined by:

(i) projecting an aggregate amount the Department expects would be paid to hospitals in the forthcoming fiscal year were the retrospective cost reimbursement system to be in effect;

(ii) subtracting the amount the Department expects to pay outside of the DRG rates;

(iii) projecting the amount the Department expects to pay using the established DRG rates;

(iv) dividing the aggregate amount in paragraph (iii) by the net amount determined in paragraph (ii).

Group Payment Rates

Effective July 1, 1989, each budget neutral group average cost per case is increased by an economic adjustment factor of 2.5% to establish the base group payment rates.

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(2) The hospital's appropriate DRG payment rate.

If a case being transferred is [illegible] the [illegible] the transferring hospital is paid the full DRG rate. If a patient is classified into one of the DRGs from 385 through 390 inclusive or 424 through 432 inclusive and is admitted to the hospital by way of a transfer from another acute care hospital covered by the prospective payment system, the [illegible] transferred patient in this situation will be paid upon the discharge of the patient the lesser of:

(1) The DRG payment rate for the case; or

(2) A marginal per diem amount for each inpatient day that is determined by dividing the hospital's DRG payment rate by the Statewide length of stay for the DRG and multiplying that amount by 60%.

Readmissions

If, after a premature discharge, a recipient is readmitted to a hospital within 31 days of discharge, the Department will deny any payment related to the readmission.

Except in cases of premature discharge, if a patient is readmitted within 31 days of discharge for the provision of services that could have or should have been provided during the previous hospital stay, the Department will combine both stays in order to determined the appropriate DRG payment.

If a patient is readmitted to the hospital due to conditions unrelated to the previous admission, the Department considers the readmission a new admission for payment purposes.

Outliers

The Department makes payment in addition to the DRG payment rate in certain instances as described below:

For DRGs that are designated as being eligible for cost outlier payments, the Department pays an additional amount for the inpatient hospital stay if the stay is found to be extremely costly in accordance with the criteria outlined under the heading of Cost Outliers. For all other DRGs, the Department pays an additional amount for the inpatient stay if the stay is extremely long as specified in the criteria outlined under the heading of Day Outliers.

Cost Outliers

For major burn cases and neonates (exclusive of normal newborns) the Department pays an amount in addition to the base DRG payment for the cases if the following conditions are met:

[illegible] DRG payment [illegible] payment.

(2) The hospital stay groups into DRG 385-390, 456-460, 472, or would have grouped into [illegible] DRG [illegible] GROUPER [illegible].

The outlier payment [illegible] percent of the calculated cost of the [illegible] percent of the base DRG amount. The Department calculates the cost of a case by multiplying [illegible] charges by the [illegible]-wide cost-to-charge ratio.

Day Outliers

For all other DRGs, the Department pays an additional amount for the hospital stay if the hospital stay exceeds the lesser of:

(1) 20 days above the geometric mean length of stay for the DRG; or

(2) 1.94 standard deviations above the geometric mean length of stay for the DRG.

If the hospital stay meets the criteria outlined above, in addition to the DRG payment rate, the Department pays a per diem amount for all days that exceed the criteria outlined above. The per diem rate paid in this instance is established by dividing the hospital's payment amount for the DRG by the statewide average length of stay for the DRG and multiplying that per diem amount by 60% to establish a marginal per diem rate for the DRG.

Services in Non-distinct Part Psychiatric Units

If a hospital does not have a psychiatric unit that is excluded from the acute care general hospital prospective payment system and provides inpatient services to a recipient with a psychiatric principal diagnosis, the Department pays a two day per diem amount for the hospital stay. The two day per diem amount is determined by dividing the DRG payment rate by the statewide average length of stay for the DRG and multiplying the result by two.

Non-distinct Part Drug and Alcohol Rehabilitation Units

If a hospital does not have a distinct part drug and alcohol rehabilitation unit approved by the Department of Health, Office of Drug and Alcohol Programs, and provides services to a recipient with a drug or alcohol principal diagnosis, the Department pays a two day per diem amount for the hospital stay. The two day per diem amount is determined by dividing the DRG payment rate by the statewide average length of stay for the DRG and multiplying the result by two.

If a hospital is approved to provide drug and alcohol services by the Department of Health, Office of Drug and Alcohol Programs, but the services are not provided in a distinct part unit, the Department pays the full DRG rate for inpatient hospital stay.

Medical Rehabilitation Services

The Department will pay an acute care hospital for medical rehabilitation services only if they are provided in conjunction with an acute care service. Payment for rehabilitation services will be made only to an enrolled distinct part medical rehabilitation unit or freestanding rehabilitation hospital.

THE OUT-OF-STATE HOSPITAL PAYMENTS

General Hospitals

Except as otherwise provided in the State Plan, for inpatient hospital services provided by an out-of-State acute care general hospital, the Department pays the lower of:

(1) The amount of charges billed by the hospital; or

(2) The Statewide average DRG payment rate, including the Statewide prospective capital add-on amount.

An out-of-State acute care general hospital that treats in any one fiscal year more than 400 Pennsylvania medical assistance inpatient cases shall be paid in accordance with methods and standards applied to in-State inpatient hospitals for acute care services. For purposes of determining eligibility for the disproportionate share payment adjustment, the Department will utilize all of the Medicaid eligible days reported by a hospital.

An out-of-State acute care general hospital located in a state contiguous to Pennsylvania shall be paid in accordance with methods and standards applied to in-State inpatient hospitals, subject to all of the following conditions:

(1) The hospital must be licensed as a hospital and enrolled as a provider in the Medicaid program in the state in which it is located.

(2) The hospital must be enrolled as a provider type 11 in Pennsylvania's Medical Assistance Program.

(3) For Fiscal Years 1992-93, 1993-94 and 1994-95, the hospital must have had at least 100 inpatient admissions of Pennsylvania medical assistance recipients, and a minimum of 95 percent of that total number must be recipients under 21 years of age.

In no case will the Department's payment rate be based on costs which are precluded from recognition by the Social Security Act.

The State regulation adopted at 55 Pa. Code 1163.65 published in the Pennsylvania Bulletin, Vol. 20, No. 22, June 2, 1990, shall not apply to West Virginia University Hospitals, Inc.

COST REIMBURSED HOSPITAL PAYMENT SYSTEM

Rehabilitation Hospitals, Distinct Part Drug and Alcohol Detoxification-Rehabilitation Units of General Hospitals and Distinct Part Medical Rehabilitation Units of General Hospitals

General Policy

The Department's rate of reimbursement for inpatient hospital services exempted from both the acute care general hospital prospective payment system and the prospective psychiatric payment system is that rate determined by the Department to be reasonable and adequate to meet the cost an efficiently and economically operated facility must incur in providing services in accordance with applicable federal and State laws, regulations and quality and safety standards.

Cost Finding

The Department's final rate of payment for cost reimbursed inpatient hospital care is based on a retrospective determination of reasonable cost in accordance with Medicare principles unless otherwise specified below and is subject to specific limits on the audited rate as set by the Department.

Malpractice insurance costs. The Department does not follow the substance or retroactivity of the malpractice insurance costs rule established by 51 F.R. 11142 (April 1, 1986). Malpractice insurance costs should be included in the administrative and general cost center and allocated according to established procedures.

Reasonable cost for MA inpatient care is computed using the Medicare (Title XVIII) retrospective reasonable cost principles, if the hospital is participating in that program. Hospitals not participating in the Medicare Program may elect to use the retrospective method prescribed for Medicare participants, or a simplified method known as the Gross RCC (Ratio of Cost to Charges) method.

Interim Payments

Prior to a settlement based on audited costs and charges, the Department pays cost reimbursed hospitals and cost reimbursed hospital units an interim per diem rate for inpatient services provided to Medical Assistance recipients. The interim per diem rate, exclusive of any disproportionate share payment adjustment paid by the Department may not exceed the ceiling which is the hospital's interim per diem rate for the preceding fiscal year increased by a factor determined by the Department.

Final Payments

The Department makes a retroactive payment for final settlement after the hospital's cost report has been audited by the Auditor General and reasonable costs have been determined as specified above under Cost Finding.

Limits to Final Payments

The Department's payment for inpatient hospital services (including acute care general hospitals and their distinct part units, private psychiatric hospitals, and freestanding rehabilitation hospitals) may not exceed in the aggregate, the amount that would be paid for those services under Medicare principles of reimbursement.

The Department's payment, exclusive of any disproportionate share payment adjustment, may not exceed the hospital's customary charges to the general public for the services.

The Department will not pay a final audited per diem rate for the hospital or hospital unit that exceeds the ceiling, which is the hospital's audited per diem rate for the hospital or hospital unit for the preceding fiscal year increased for inflation by the following inflation factors:

(1) 5.6 percent to account for Fiscal Year 1988-89 inflation.

(2) 5.0 percent to account for Fiscal Year 1989-90 inflation.

(3) 5.3 percent to account for Fiscal Year 1990-91 inflation.

(4) 5.2 percent to account for Fiscal Year 1991-92 inflation.

(5) 4.6 percent to account for Fiscal Year 1992-93 inflation.

(6) 4.3 percent to account for Fiscal Year 1993-94 inflation.

This inflation factor is applied effective July 1, 1993, for all inpatient rehabilitation facilities which qualified for a disproportionate share payment, exclusive of supplemental disproportionate share payments, in Fiscal Year 1992-93. The inflation factor is applied effective January 1, 1994, for other inpatient rehabilitation facilities.

(7) For the period January 1, 1995 through December 31, 1995, the amount determined under (6) will be increased by 3.7 percent.

(8) For the period January 1, 1996 through December 31, 1996, the amount determined under (7) will be multiplied by .95.

(9) For the period January 1, 1997 through December 31, 1997, the amount determined under (8) will be increased by 2 percent.

For the period January 1, 1996 through December 31, 1996, the Department limits interim and final payment to rehabilitation providers to $935.89 per day. For the period January 1, 1997 through December 31, 1997, the Department limits interim and final payment to rehabilitation providers to $954.61 per day.

Nonallowable Depreciation and Interest Costs

The following limitations will apply except in cases in which the Department finds it necessary to take measures to assure the availability of rehabilitation services to Medicaid recipients. In such cases the Department may reimburse rehabilitation facilities solely under Medicare cost reimbursement principles.

Capital costs for new or additional beds, for all providers exempt from the prospective payment system, are not allowable under the Medical Assistance Program unless they meet the applicable conditions specified below.

(1) For rehabilitation hospitals, capital costs are nonallowable unless the hospital was constructed prior to July 1, 1983, or was issued a Section 1122 approval letter, a Certificate of Need, or a letter of nonreviewability by the Department of Health prior to July 1, 1983.

(2) For distinct part drug and alcohol rehabilitation units of general hospitals and rehabilitation hospitals not covered under (1), capital costs are nonallowable unless a Certification of Need for the new or additional beds or a letter of nonreviewability had been issued by the Department of Health prior to July 1, 1986.

(3) For distinct part medical rehabilitation units of general hospitals, capital costs are nonallowable unless:

(i) the new or additional beds were placed in service prior to July 1, 1988, and are located in a medical rehabilitation unit which was enrolled in the Medical Assistance Program with an effective date no later than July 1, 1988; or

(ii) a Section 1122 approval letter, a Certificate of Need, or a letter of nonreviewability for the beds was issued by the Department of Health prior to July 1, 1988.